Activity (TMA) in accordance with current contract requirements for not at risk funds. There are specific reporting data elements for this demonstration to include special processing codes for network and non-network claims, enrollment status code, voucher reporting by branch of service specific to the demonstration and pricing profile code. There are no additional fields which have to accommodate new values for this demonstration.

b. Network Claims

(1) *The contractor shall follow TRICARE processing requirements, guidelines standards, and reporting requirements for network claims.*

(2) *The contractor shall reimburse network claims in accordance with existing TRICARE network provider agreements.*

c. Non-Network Claims

(1) *The contractor shall apply the clean/non-clean claims definitions in Figure 2-20-N-10.*

(2) *The contractor shall pay 95% of all clean non-network claims within 30 calendar days of receipt.*

(3) *The contractor shall follow HCFA's requirements concerning interest penalty payments as a result of late claims payments for Medicare patients. Any interest penalties imposed by HCFA as a result of late claims payment shall be the responsibility of the contractor without reimbursement by the government. A report of all interest penalties shall be furnished to the Lead Agent each quarter.*

(4) *The contractor shall issue 95% percent of all initial determinations within 60 calendar days of receipt. (See Figure 2-20-N-10.)*

(5) *Failure to issue a written notice within 60 days of receipt of the claim constitutes an adverse initial determination, which the beneficiary or provider may appeal, and the beneficiary and provider shall be so advised by letter and offered appeal rights. (See Figure 2-20-N-10.)*

(6) *Non-institutional claims shall be reimbursed in accordance with current CMAC rates.*

(7) *Institutional claims shall be reimbursed using the current Medicare Prospective Payment System.*

(8) *Emergency and urgent care claims will be paid billed charges.*

(9) *TRICARE ClaimCheck will not apply to non-network claims.*

d. Readiness Testing

Prior to the start of healthcare delivery, the contractor shall demonstrate the ability of its staff and automated claims processing system to accurately process claims in accordance with stated requirements. This shall be accomplished through a government administered test to be conducted no later than 30 days prior to the start of

healthcare delivery, on a date mutually agreed upon by the government and the contractor. The test shall include all front end processes required including enrollment, loading of needed provider files, issuance of required authorizations and referrals, processing both network and non-network professional and institutional claims for enrolled beneficiaries and imaging of claims. Also required shall be the generation of Health Care Service Records (HCSRs) as well as the data required by the Medicare Processing Center (MPC).

e. Reporting

(1) *The contractor shall generate and submit a HCSR for all claims processed.*

(2) *No later than the fifteenth (15th) day of the month following the month in which a claim is paid, the contractor shall submit to the MPC UB92 or HCFA 1500 data, as appropriate, for all claims.*

(3) *The contractor shall provide Monthly Workload and Cycletime Aging Reports in the required format provided in OPM Part One, Chapter 3. These reports shall arrive by the 15th calendar day of each month reporting for the previous month. Separate reports are required for non-network clean and non-clean claims by each MTF.*

f. Audits

All TRICARE Senior Prime claims are excluded from the quarterly audits.

14. Utilization Management/Quality Assurance

a. General

Utilization management, including case management and discharge planning, and quality assurance for this demonstration shall be performed in accordance with the current Managed Care Support Contract in the Region and current HCFA requirements, unless otherwise specified under separate contract modifications. Enrollees in TRICARE Senior Prime shall access network or non-network provided specialty care only through an approved referral by their MTF PCM, unless otherwise specified in this chapter.

b. Peer Review Activities

The contractor shall support the MTF in fulfilling requirements for the provision of medical records for network and non-network care, as requested by the MTF for review by the HCFA Peer Review Organization (PRO). As a general rule, medical records requested for review shall be provided within fifteen (15) days for network providers and within thirty (30) days for non-network providers. Figure 2-20-N-9 provides information on the PRO process with which the MTF will be required to comply.

15. Appeals

a. General Information

For purposes of this demonstration project, the appeals process involves only those issues where an initial review resulted in an adverse determination for the enrollee. All other issues and complaints by either providers or beneficiaries shall be considered grievances. Medicare (HCFA) may be involved in the appeals process but considers

the grievance process to be internal to the plan. Grievances are covered in Section II.N.16. The MCS contractor, MTF, and Lead Agent shall utilize the appeals process at Figure 2-20-N-10 to develop an appeals process specific to the TRICARE Senior Prime Program for their site. The appeals process shall be included in the policies and procedures developed to manage the plan and shall be in place prior to the HCFA Site Survey.

b. *Initial Reviews*

(1) *Definition*

Initial adverse review decisions (initial denial determinations) are fully defined in 42 CFR 417.606(a). Briefly they are generally determinations which deny services or payment based on the facts, coverage, or medical grounds.

(a) *The facts include issues of enrollment, lack of authorization (including failure to follow prescribed referral and authorization requirements, unauthorized use of non-network provider, etc.).*

(b) *Coverage may relate to either Medicare proscribed services (in which case Medicare may be involved in the appeals process), or to additional coverage provided by the TRICARE Senior Prime plan (in which case the appeals process shall follow that of the current MCS contract).*

(c) *Medical grounds are based on medical judgement (e.g., non-emergency, non-urgent, not a skilled or not the appropriate level of care, not medically necessary, not the treatment option offered by the Plan, etc.).*

(2) *Performing Initial Reviews*

Unless otherwise specified under separate contract, initial reviews described above shall be accomplished in accordance with the current MCS contract and/or as clarified in the LA/MTF/MCS contract memorandum of agreement/understanding.

(3) *Initial Review Determinations*

The issuance of an initial denial determination letter to beneficiary or provider shall be in accordance with the jointly developed appeals process and shall meet HCFA requirements.

c. *Reconsiderations*

The appeal of an initial determination shall be conducted in accordance with the policies and procedures developed to manage the plan (see Section II.N.15.a.). Reconsiderations which result in a total or partially unfavorable response for the beneficiary shall be referred to the Center for Health Dispute Resolution (CHDR) in accordance with HCFA requirements.

d. *Expedited Reconsiderations*

Expedited reconsiderations shall be conducted in accordance with the above guidelines and those found in Figure 2-20-N-10.

16. Grievance Process

The contractor shall support the plan's resolution of beneficiary grievances relating to care received from a network or non-network provider. (See Figure 2-20-N-11 for an explanation of "Grievances.")

17. Beneficiary Services

The contractor shall provide the same level of services and responses to telephonic, in-person, and written inquiries with the same standards as applicable to the current MCS contract and HCFA requirements.

18. Working Aged Enrollees

a. *The contractor shall identify and administer a HCFA Working Aged Survey (Figure 2-20-N-12) to all aged Medicare beneficiaries upon enrollment in TRICARE Senior Prime and annually thereafter. The contractor shall, through biennial advertisement (newsletters or other means) inform beneficiaries of the requirement to provide notification of changes in working aged status. The contractor shall follow-up on unanswered surveys with at least two telephonic attempts within the first 30 days and one written attempt within the second thirty (30) days, if needed, to obtain responses from enrollees ages 65 to 75. The contractor shall, upon request, provide an enrollee with a second copy of the HCFA Working Aged Survey.*

b. *The contractor shall provide survey data to HCFA via the MPC in the format as required in Figure 2-20-N-13, shall verify data received from HCFA via the MPC, and incorporate a working aged identifier in the coordination of benefits activities.*

c. *The contractor shall provide an initial report to the appropriate MTF on the working aged status of enrollees within thirty (30) days of the open enrollment period and shall provide updates within ten (10) days of a new enrollment or any changes in an enrollee's working aged status.*

19. Payment for Contractor Services Rendered

The contractor shall report the TRICARE Senior Prime claims on separate vouchers according to the ADP Manual, Chapter 2. The HCSR data for each claim must reflect the appropriate data element values. To distinguish a TRICARE Senior Prime (Medicare) voucher from a voucher for other TRICARE, the contractor shall utilize the specific Voucher Branch of Service Codes mandated in the ADP Manual for use in reporting such claims. The contractor shall process payments via Letter of Credit on a not-at-risk basis for the healthcare costs incurred for each TRICARE Senior Prime claim processed to completion, upon acceptance of the vouchers by TMA.

20. Transitions

a. Change in Contractor

All transition requirements as defined in OPM Part One, Chapter 1, Section VIII. apply.

b. *Termination of Demonstration*

DoD and HCFA will develop procedures for notification of beneficiaries and transitioning out of the demonstration and back into other Medicare coverage. These changes will be defined and implemented by contact modification.

Figure 2-20-N-1 TRICARE Senior Demonstration Sites and Timeline

			WAIT LIST
TRICARE Region 1:	**Dover Air Force Base Dover Delaware**		
Estimated enrollment capacity:		*1,500*	*750*
TRICARE Region 4:	**Keesler Air Force Base Biloxi, Mississippi**		
Estimated enrollment capacity:		*2,200*	*900*
TRICARE Region 6:	**Brooke Army Medical Center and Wilford Hall Medical Center San Antonio, Texas Sheppard Air Force Base, Wichita Falls, Texas Fort Sill, Lawton, OK**		
Estimated enrollment capacity:			
	Brooke Army Medical Center	*5,000*	*2,500*
	Wilford Hall Medical Center	*5,000*	*2,500*
	Ft.Sill	*1,400*	*700*
	Sheppard AFB	*1,300*	*650*
TRICARE Central Region:	**Fort Carson and the Air Force Academy Colorado Springs, Colorado**		
Estimated enrollment capacity:			
	Fort Carson	*2,000*	*1,000*
	Air Force Academy	*1,200*	*600*
TRICARE Region 9:	**Naval Medical Center San Diego San Diego, CA**		
Estimated enrollment capacity:		*4,000*	*2,000*
TRICARE Region 11:	**Madigan Army Medical Center Fort Lewis, WA**		
Estimated enrollment capacity:		*3,300*	*1,500*

"Aging-in" is projected to increase enrollment by 10% each year of the demonstration.

Figure 2-20-N-2 KEY DATES:

Activities	Site	1998 Est Completion Date
Marketing		
Marketing Materials Approved by HCFA (incl in HCFA application)	Madigan	Completed
	San Antonio	26 Jun
	Sill/Sheppard	Early July
	San Diego	Early July
	Keesler	Early July
	Colo. Springs	Early August
	Dover	Early August
Marketing Materials Distributed to Sites	TMA	23 Jun
Marketing Begins	Madigan	1 Jul
	San Antonio	1 Aug
	San Diego	1 Aug
	Sill/Sheppard	1 Sep
	Keesler	1 Sep
	Colo. Springs	1 Oct
	Dover	1 Oct
Enrollment		
MPC Enrollment System Operational (TMA)	San Antonio	1 Jul
	Madigan	1 Jul
	Sill/Sheppard	1 Jul
	San Diego	1 Jul
	Colo. Springs	1 Jul
	Keesler	1 Aug
	Dover	1 Aug
MCS Contractor System in Place	San Antonio	1 Jul
	Madigan	1 Jul
	Sill/Sheppard	15 Jul
	San Diego	15 Jul

Figure 2-20-N-2 KEY DATES: (Continued)

Activities	Site	1998 Est Completion Date
	Keesler	15 Jul
	Colo. Springs	15 Jul
	Dover	15 Jul
Enrollment Begins (applications available and may be submitted)	Madigan	15 Jul
	San Antonio	15 Aug
	San Diego	15 Aug
	Sill/Sheppard	15 Sep
	Keesler	15 Sep
	Colo. Springs	15 Oct
	Dover	15 Oct
Healthcare Delivery Readiness		
Referral Systems Ready (HCF functions for network referrals)	Madigan	1 Aug
	San Antonio	1 Sep
	San Diego	1 Sep
	Sill/Sheppard	1 Oct
	Keesler	1 Oct
	Colo. Springs	1 Nov
	Dover	1 Nov
Healthcare Delivery Begins		
	Madigan	1 Sep
	San Antonio	1 Oct
	San Diego	1 Oct
	Sill/Sheppard	1 Nov
	Keesler	1 Nov
	Colo. Springs	1 Dec
	Dover	1 Dec

Figure 2-20-N-3 Cost-Shares

Listed below are the applicable charges when an enrollee receives care in the civilian community.

Service	Cost-Share
Office visit; medical and surgical care in provider's office, a hospital, or a skilled nursing facility	*Office Visit - $12*
Manual manipulation for subluxation of the spine when demonstrated by x-rays	*Office Visit - $12*
Second opinion by another network Physician prior to surgery	*Office Visit - $12*
Drugs and biologicals which cannot be self-administered, and are furnished as a part of a physician's services	*None*
Diagnostic and therapeutic laboratory and x-ray services, including portable x-rays used in the home	*Office visit charge $12 Free if part of another office visit.*
Outpatient services received at a participating hospital for diagnosis or treatment of an illness or injury	*Office Visit - $12*
Certain specified outpatient surgical procedures performed in an ambulatory surgical center	*Copay - $25*
Outpatient mental health services - One hour of therapy no more than two times per week when medically necessary	*Copay $25 individual/ $17 group*
Independently practicing outpatient physical therapy and occupational therapy services	*Copay $12*
Comprehensive outpatient rehabilitation facility services	*Copay $12 per service*
Transfusions of blood	*Copay $25*
Medical supplies, such as dressings, splints, and casts	*A cost share of 20% of negotiated fee*
Renal dialysis	*Copay $25*
Ambulance services	*Copay $20*
Ostomy supplies and prosthetic devices such as: braces for arm, leg, back and neck, artificial limbs, artificial eyes, contact lenses replacing natural lenses, and breast prostheses after surgery	*A cost share of 20% of negotiated fee*
Durable medical equipment, such as oxygen equipment, wheelchairs, and other equipment when prescribed by a Plan Physician for use in the home	*A cost share of 20% of negotiated fee*
Pneumococcal vaccine and its administration	*No Copay*
Hepatitis B vaccine for members considered to be at high or intermediate risk of contracting disease	*No Copay*

Figure 2-20-N-3 Cost-Shares (Continued)

Home health care services furnished by a participating home health agency, when authorized	*No Copay*
Screening pap smear	*No Copay*
Breast cancer screening (Mammography) - Medicare coverage is at least every other year for woman 65 or older	*No Copay*
Therapeutic shoes for those suffering from severe diabetic foot disease	*20% of negotiated fee*
Influenza vaccine	*No Copay*
Other age-appropriate preventive services included eye exams, immunizations, blood pressure screening, hearing exams, sigmoidoscopy or colonoscopy, serologic screening and certain education and counseling services	*No Copay*
Retail Pharmacy Network - up to 30 day supply	*Copay $9 per prescription*
Mail service pharmacy - up to 90 day supply	*Copay $8 per prescription*
Emergency services: Emergency and urgently needed care obtained in an emergency room, on an outpatient basis, both network and non-network and in and out of service area	*Copay $30 per visit*
Partial hospitalization for alcoholism treatment - up to 21 days for rehabilitation on a limited hour per day basis	*Copay $40 per visit*

Figure 2-20-N-3 Cost-Shares (Continued)

This chart lists the applicable charges when an enrollee receives care as an inpatient. Rates subject to change based on future Medicare benefits determinations.

Inpatient Hospital Service	Military Hospital	Network Hospital
Acute inpatient admissions	*No charge*	*$11 per day/minimum $25 per admission*
Inpatient mental health/substance abuse	*No charge*	*Copay $40 per day*
Partial hospitalization for mental health	*No charge*	*Copay $40 per day*
Alcoholism - with authorization, 7 days for detoxification and 21 days for rehabilitation per 365 days. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward limit for mental health benefits.	*No charge*	*Copay $40 per day*
Inpatient care in a Medicare - participating skilled nursing facility when you need skilled level of care following a hospital stay		*No charge for the first 20 days; an additional 80 days may be authorized with a cost-share at the current Medicare rate.*
Hospice care - pain relief, symptom management and support services for the terminally ill.		*Same as Standard Medicare*
Inpatient respite care		*5% of the payment made by HCFA for a respite day.*
Home health care - furnished by participating home health agency, when authorized		*No charge*

Figure 2-20-N-4 Information Management Functional Requirements

INFORMATION MANAGEMENT FUNCTIONAL REQUIREMENTS

TRICARE SENIOR PRIME DEMONSTRATION PROJECT

Information Management, Technology & Reengineering (IMT&R)
June 11, 1998

Version 2

- Clarification of CEIS reporting requirements

Figure 2-20-N-4 Information Management Functional Requirements (Continued)

INFORMATION MANAGEMENT
FUNCTIONAL REQUIREMENTS

DESCRIPTION

The TRICARE Senior Prime functional requirements identify the information system capabilities and interface requirements for the Department of Defense (DoD) Military Health Systems (MHS) in support of the demonstration project.

PURPOSE

The purpose of this document is to define the functional requirements for the DoD systems supporting the TRICARE Senior Prime demonstration project to ensure a successful implementation of the program.

1. SCOPE

1.1 Identification

The Department of Health and Human Services (DHHS), the Health Care Financing Administration (HCFA), the DoD, and the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) have agreed to support a demonstration project, entitled TRICARE Senior Prime, through 31 December 2000, under which Medicare will reimburse the DoD for care it provides to Medicare-MHS dual-eligible beneficiaries. The goal of this demonstration is to implement a cost-effective alternative for delivering accessible and quality care to dual-eligible (Medicare and military eligible) beneficiaries while ensuring that the demonstration does not increase the total Federal cost for either agency.

Enrollment into the TRICARE Senior Prime demonstration project is limited to dual-eligible beneficiaries who meet all of the following eligibility requirements:

- Are entitled to Medicare Part A, enrolled in Medicare Part B and are eligible for care in the MHS as described in Section 1074(b) or 1076(b) of Title 10 United States Code, excluding beneficiaries diagnosed with end stage renal disease or beneficiaries who have elected the Hospice benefit;
- Are age 65, or will attain age 65 on or prior to the first day of health care delivery, or will "age-in" to the demonstration by being enrolled in TRICARE Prime with a PCM in the demonstration MTF and becoming Medicare eligible during the demonstration;
- Are residents of the geographic areas covered by the demonstration and where enrollment in the demonstration is offered; and

Figure 2-20-N-4 Information Management Functional Requirements (Continued)

- Have received services as a dual eligible prior to January 1, 1998, or became eligible for Medicare, Part A on or after December 31, 1997.

Participation in TRICARE Senior is voluntary. Beneficiaries must apply for enrollment in the program. There are capacity limits per demonstration service area. No new MTFs will be built and no existing facilities will be expanded with funds from the demonstration project.

Six service areas have been selected by the DHHS and the DoD for participation in the demonstration project. These service areas include the following:

1. Brooke Army Medical Center, San Antonio, Texas,
   Wilford Hall Medical Center, San Antonio, Texas,
   Ft. Sill, Lawton, Oklahoma, and
   Sheppard Air Force Base, Wichita Falls, Texas
2. Madigan Army Medical Center, Fort Lewis, Washington
3. Naval Medical Center San Diego, San Diego, California
4. Keesler Air Force Base, Biloxi, Mississippi
5. Ft. Carson, Colorado Springs, Colorado and
   US Air Force Academy, Colorado Springs, Colorado
6. Dover Air Force Base, Dover, Delaware

The DoD Information Management/Information Technology (IM/IT) systems supporting the TRICARE Senior Prime demonstration are as follows:

- the Managed Care Support Contract Systems (MCSC)
- the Composite Health Care System (CHCS)
- the Ambulatory Data System (ADS)
- the Defense Enrollment Eligibility Reporting System (DEERS)
- the Corporate Executive Information System (CEIS)
- the IOWA Foundation Medicare Processing Center (MPC)
- the TRI-Service Management Activity, Acquisition Management and Support (TMA AM&S)
- Medical Expense and Performance Reporting System (MEPERS)
- Expense Assignment System (EAS)
- National Mail Order Pharmacy (NMOP)

Figure 2-20-N-4 Information Management Functional Requirements (Continued)

1.2 Project Overview

TRICARE Senior Prime is one of two health care delivery systems defined in the Memorandum of Agreement (MOA) for the Medicare Demonstration of Military Managed Care. Approximately 1.1 million Americans age 65 and older are beneficiaries not only of the MHS, but also of Medicare. These dual-eligible beneficiaries do not have a Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) entitlement, but are eligible for care in a MTF on a space-available basis. TRICARE Senior Prime, a DoD Medicare at-risk HMO program initiative, offers dual-eligible beneficiaries the opportunity to enroll into this demonstration. Enrollment into this demonstration is scheduled to begin July 15, 1998. Multiple AISs, to include the CHCS, ADS, CEIS, and DEERS must ensure data flow between MTFs, the MPC, and the HCFA. This effort encompasses identification of critical data, transfer of data, data storage, and data standardization.

1.3 Document Overview

This document defines the functional requirements for the enrollment and claims data flow process amongst the systems supporting the TRICARE Senior Prime demonstration project within the DoD. The functional requirements section presents each system's requirements for enrollment, claims, and reporting in the following order:

2.1 MCSC
2.2 CHCS
2.3 ADS
2.4 DEERS
2.5 CEIS
2.6 MPC
2.7 TMA, AM&S

A graphical representation of the interfaces and data flow processes among the application information systems (AIS) for beneficiary, enrollment, and claims/clinical data can be found in Exhibit 1 and Exhibit 2. General security and privacy IM/IT requirements for TRICARE Senior Prime can be found in Section 4 of this document.

2. FUNCTIONAL REQUIREMENTS

2.1 MCSC

The MCSCs are responsible for all aspects of enrollment and disenrollment in the TRICARE Senior Project. Chapter 20 of the OCHAMPUS Manual 6010.49-M, Operations Manual, Part Two, February 24, 1998, stipulates the business rules and processes for the MCSCs in managing TRICARE Senior Project enrollment as follows: 1) health care finder, 2) health care services, 3) eligibility and enrollment, 4) utilization management, 5) claims processing, 6) reporting requirements, 7) marketing, 8) beneficiary services, and 9) medical peer review. Within each

Figure 2-20-N-4 Information Management Functional Requirements (Continued)

demonstration area, the MCSC will communicate and provide statistics to the Lead Agent and MTF Commanders on the TRICARE Senior Project according to the MOA.

Enrollment Data Requirements:

2.1.1 The MCSCs shall process TRICARE Senior Prime applications from MHS beneficiaries.

2.1.2 The MCSCs shall verify MHS eligibility in DEERS via MPC and Medicare eligibility with HCFA via MPC.

2.1.3 The MCSCs shall enter enrollment, enrollment updates and disenrollment information in the MPC system for HCFA enrollment processing.

2.1.5 The MCSCs shall enroll MHS-eligible, HCFA-confirmed beneficiaries into CHCS-MCP, which automatically transmits enrollment data to DEERS.

2.1.6 The MCSCs shall produce and send the enrollment confirmation letter, enrollment card and other enrollment materials to the TRICARE Senior Prime enrollee.

2.1.6 The MCSCs shall update enrollment information, to include entry of disenrollments when applicable, into the CHCS MCP, which automatically updates DEERS, based on the MPC DEERS/HCFA reconciliation report.

2.1.7 The MCSCs shall disenroll TRICARE Senior Prime beneficiaries in accordance with current contract requirements.

Claims Data Requirements:

2.1.8 The MCSCs shall create and submit a Health Care Service Record (HCSR) to TMA, AM&S for each TRICARE Senior claim in accordance with current contract requirements.

2.1.9 The MCSCs shall create and submit monthly Uniform Billing (UB) 92 and HCFA 1500 data to the MPC for each claim processed for TRICARE Senior Prime enrollees.

Report Requirements:

All reports required under this section shall be provided in electronic format. The detailed format and data transmission protocols will be specified during detail design.

2.1.10 The MCSCs shall maintain a daily list of TRICARE Senior Prime applications processed via MPC.

Figure 2-20-N-4 Information Management Functional Requirements (Continued)

2.1.11 The MCSCs shall provide HEAR data results reports to the enrollee and the MTF. The HEAR data shall be provided to the government in an electronic medium in a form that can be manipulated by the government.

2.1.12 The MCSCs shall establish and maintain a wait list of eligible applicants via MPC at the level established by the participating site and monitor enrollment levels.

2.1.13 The MCSCs shall maintain and report enrollment processing information as specified by the current contract.

2.1.14 The MCSCs shall maintain and report enrollee disenrollment rates and reasons, complaint and appeal information as specified by the current contract.

2.1.15 The MCSCs shall maintain and report referral and access information as specified by current contract requirements.

2.1.16 The MCSCs shall maintain and report utilization management/quality assurance information, to include case management and discharge planning, in accordance with the current contract requirements.

2.2 CHCS

The CHCS is a fully integrated, automated health care system developed and maintained by the DoD MHS for use in all MTFs. The CHCS provides the appointment and health care delivery system used by the MTFs for TRICARE Senior Project enrollees. The TRICARE Senior Project enrollee appointments, referrals, clinical, ancillary orders and results, and admissions and dispositions will be performed using the CHCS for care rendered at the MTF. Enrollment for TRICARE Senior Prime beneficiaries will be entered into the CHCS MCP module after HCFA enrollment has been confirmed. The CHCS will verify MHS eligibility through an interactive eligibility check with the DEERS. In addition, the CHCS will be used to enter the TRICARE Senior Project enrollment start and end dates, assign a Primary Care Manager (PCM), and assign the alternate care value (ACV) of 'D.' Enrollment information will then be transmitted to DEERS.

Enrollment Data Requirements:

2.2.1 The CHCS shall be the data entry system for TRICARE Senior Prime enrollment and disenrollment information to DEERS for TRICARE Senior Prime.

2.2.2 The CHCS shall provide the capability to enroll, disenroll, and provide update capabilities for TRICARE Senior Prime.

2.2.3 The CHCS shall automatically assign an ACV of 'D' to beneficiaries who meet the following criteria:

Figure 2-20-N-4 Information Management Functional Requirements (Continued)

- Direct care eligible based on a current DEERS check (dual eligible per enrollment information)
- Age 65 or over on the enrollment start date
- CHAMPUS ineligible

2.2.4 The CHCS shall default the beneficiary's TRICARE Senior Prime enrollment start date as the first day of the coming month. The enrollment start date shall be an editable field. The CHCS shall allow the user to edit the enrollment start date to any first of the month date in the past or future.

2.2.5 The enrollment status of the Medicare enrollee in TRICARE Senior Prime shall be continuous, with an indefinite date entered into CHCS MCP. The end enrollment date shall be an editable field.

2.2.6 The CHCS shall provide the capability to enter TRICARE Senior Prime enrollments as individual enrollments; the family enrollment option shall not be available for TRICARE Senior Prime enrollments.

2.2.7 The CHCS shall provide the capability to assign a PCM for a TRICARE Senior Prime enrollee in the direct care system. The CHCS shall transmit TRICARE Senior Prime enrollments with an ACV of 'D' to the DBERS, regardless of the CHCS host's enrollment mode.

2.2.9 The CHCS shall maintain an enrollment history file for patients that have an ACV of 'D' to include current, historical, or future enrollments in TRICARE Senior Prime.

2.2.10 During enrollment processing, the CHCS shall provide for entry and updates of registration and other health insurance (OHI) data.

Claims Data Requirements:

2.2.11 The CHCS shall transmit the PCM Location Code, Enrollment DMIS ID, Treatment DMIS ID, ACV, and PCM ID with the Standard Inpatient Data Record (SIDR) to the CEIS.

2.2.12 The CHCS shall transmit the PCM Location Code, Enrollment DMIS ID, Treatment DMIS ID, ACV, and PCM ID with the HL-7 ancillary data records to the CEIS.

Report Requirements:

2.2.13 The CHCS shall provide a monthly TRICARE Senior Prime enrollment file to CEIS for all TRICARE Senior Prime enrollees active for the reporting month for each Medicare site to include: sponsor SSN, enrollee family member prefix (FMP), enrollee SSN,